



Energy use and End-use Technologies: Organizational and Energy Analysis in Italian Hospitals

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ABSTRACT

The paper aims to evaluate the possible sustainable management of energy, within the 1062 Italian hospitals. The hospital is the only public building that operates continuously throughout the year. It is a 24-h facility. Although the theme has been treated in the literature, there is no empirical evidence concerning the same country of the European Union to the number of structures analyzed and energy consumption. Furthermore, Italy is a country heavily dependent on sources of energy supply. The methodological approach has been that of a joint evaluation both of organizational types that is energetic. In the discussion, possible solutions emerge, operational interventions, to make the energy management of hospitals, more efficient. The role of the energy manager and the presence of structures dedicated to energy management emerge as the main bottlenecks for achieving better energy efficiency.

Keywords: Energy Policy, Digital Technologies, Management, Health

JEL Classifications: I15, I18, O31

1. INTRODUCTION

In recent years, modern society is increasingly interested in the energy issue (Clarke et al., 2015), understood as sources of supply (Russo et al., 2021), consumption (Su et al., 2022), and distribution (Patil et al., 2021) of energy. The comparison concerns the economic systems (Liu et al., 2022), the technological evolution (Wen et al., 2022) and the environmental situation (Alola et al., 2021) of the individual States (Yang et al., 2020) and the entire Planet (Smol, 2022). The growing energy demand highlights the need for individual states and the internal Planet to pay attention to the economic and environmental costs arising from the use of different energy carriers, shifting attention to the issue of energy efficiency (Economidou et al., 2022). In this context, the total use of energy in Italy, related to the hospital sector is about 35% of the total (OECD, 2021). Hospital facilities are a very complex structure (Mavrotas et al., 2008), not only for the size and the different technologies that coexist within it (Baltussen et al., 2019) but above all because it is the only public building that

must maintain a constant service every day of the year, 24 h a day (Ai et al., 2022).

Energy is one of the fundamental elements for the functionality of healthcare facilities and the different sources converge and interact with each other to ensure patients, employees and users, a safe, comfortable and continuous service (Szczygielski et al., 2021; Erdoğan et al., 2020). Nevertheless, it is one of the contexts where there is the greatest margin of difficulty for the implementation of efficient energy strategies. The difficulties relate to a series of elements such as buildings that do not have modern structures and are difficult to maintain and innovate (Yu et al., 2022). It should also not be forgotten that an improvement in energy efficiency must not necessarily result only in an economic advantage detectable in the bill, but can also be used to increase thermo-hygrometric well-being and the health of the environment, all the more reason given the very purpose of the buildings under consideration and the particular condition in which its users are located.

Some studies (Bellini et al., 2020) have thoroughly analyzed the general situation of the Italian health heritage about Europe (Lal et al., 2021), to evaluate investment policies and the definition of appropriate intervention strategies. The monitoring activities were carried out both to analyze the building and structural context (Martinez et al., 2022) and to analyze the energy consumption of Italian hospitals. This comparison with the other realities of Europe, highlights what will be evaluated in our research issue, (RQ): How is it possible to improve the energy efficiency of Italian hospitals? In this work, the introduction is followed by the literature review, after the methodology, we present the results of the research, followed by the discussions, and finally the conclusions of the work. In the next paragraph, concerning the research issue, we highlight the reference literature.

2. LITERATURE REVIEW

The current pandemic has dramatically highlighted the central role of the hospital structure in terms of the organization and delivery of health for our well-being, as well as that of the multiplicity of different energy services essential to deliver health (Yaps et al., 2021; Santiago et al., 2021; Liang et al., 2019; Castán Broto and Kirshner, 2020; Ejemeyovwi, 2019). Unfortunately, in Italy, investments in energy efficiency have fallen due to the economic crisis, as underlined by the International Energy Agency in its recent report (IEA, 2022). Moreover, in this context the response of the European Union (2022) is not yet clear, unlike other crises, see the pandemic from SARS Covid 19 (Marino and Pariso, 2021b, Fischer, 2020). The role played by the European Government in the implementation of measures to support the energy crisis. Avoiding generating a new economic crisis is fragmented and does not show strong elements of union between the 27 Member States. In this context, the hospital principals (Liang et al., 2019; Weyman-Jones, 2019; Fawcett and Killip, 2019) are involved in a dual strategic path: they deliver health but, to deliver it consumes energy, are energy-intensive structures, therefore, for the hospital principals have set out a challenging process:

The European Parliament is calling on the Council and the Commission to ensure that the European Parliament is fully involved in the implementation of the Kyoto Protocol. The hospitals in Europe (Mossialos and Le Grand, 2019; Johnson et al., 2019) have evidenced that to withstand this challenge it is necessary to combine adequate normative support (Prada et al., 2020) the collaboration of various subjects, identifying the best projects and the sharing of ideas and cutting-edge technologies (Grillone et al., 2020; Marino and Pariso, 2021). National experiences, in particular Italian ones, confirm the presence of several barriers to the full implementation of energy efficiency potential and, in particular: a market where consumers and businesses still experience long return times, difficult access to investment capital and dispersion of measures, resulting in high transaction costs (Saint Akadiri et al., 2019; Pichler et al., 2019; Martino et al., 2019). The role of the individual member countries of the European Union is strategic to build virtuous processes of implementation of operational projects that combine care and energy consumption (Marino et al., 2022; Marino and Pariso, 2021a). Improving the energy performance of Italian hospitals

is one of the main objectives to accompany the energy transition of this country and the energy efficiency of the National Health System (Alola et al., 2019; Economidou et al., 2020). It should not be forgotten that energy efficiency is a lever that starts from the bottom up and is transversal to several economic sectors.

The energy upgrading of hospitals (Fox et al., 2019; Li et al., 2019) would see its indirect benefits greatly reduced if not supported by the efficiency of the industrial sector associated with it. The health sector, with the peculiarities of the sectors included in it, is affected by redevelopment interventions as well as by interventions to improve the efficiency of its service processes. Efficiency must be supported by emerging technologies (Bygstad and Øvrelid, 2020; Moro Visconti and Morea, 2020), such as the predisposition to the intelligence of buildings, technologies for the built environment, heat recovery and solutions for energy communities. Particularly, the moment of great changes that we are going through has shown with great evidence the importance of the scientific committee to seek solutions, for our social and economic well-being (Marino et al., 2021a). Smart Readiness Technologies (Ronaghi, 2022; Sebastian, 2019) is seen by the European Commission as an important tool that can, on the one hand, encourage investment in Smart Ready Technologies (SRT) and, on the other hand, help SRT producers to improve their supply and organize it according to the types of demand (Santiago et al., 2021). Hence the importance of defining the Smart Readiness Indicator to promote the spread of smart building technologies, (Awada et al., 2021; EN ISA, 2022) quantify the level of “smartness” of buildings and certify the benefits that result in terms of energy efficiency and performance (Woll et al., 2023; Kumar et al., 2020; Fisher et al., 2020; Marino and Pariso, 2021b).

The role of information and training is strategic, in particular for the type of these structures, hospital facilities, which is very complex because it often combines the typical energy characteristics of a multiplicity of other types of “energy consumers”: From the real estate/hotel sector (hospitals) (Ismail et al., 2020; Papparizos et al., 2020; Tavakoli et al., 2020) to the energy generation and transformation sector (large cogeneration/trigeneration plants), to research and sports (rehabilitation). This energy complexity can be broken down into prime factors by using the energy diagnosis (Alzubaidi and Soori, 2012; MacNaughton et al., 2018) report in the health field, providing an industry-specific data collection methodology, standardizing the technical glossary and defining minimum levels for energy monitoring, which can be an important tool for the definition of energy efficiency actions useful to define reliable reference parameters. Accurately estimating the real energy and economic savings of a building (Pallis et al., 2021; Yun et al., 2020; Giraudet, 2020; Dominguez-Delgado et al., 2020) requires an adequate knowledge of the building-plant system, or the characteristics of the building envelope, but also of the plant components present and how these two systems interact with each other.

Enhancing the energy supply chain of Italian hospitals (Moro Visconti and Morea, 2020; Klemeš et al., 2020; Sarkis, 2020; Martiniello et al., 2020) is a strategic priority that requires investment, simplification of authorization procedures and a push

to the conversion of traditional buildings in the key of circular economy (Khadim et al., 2022; Marino and Pariso, 2020). In this context, energy efficiency can make an essential contribution to the transition to stimulating economic growth (Khan et al., 2021; Kahouli, 2018; Zhou et al., 2021). The phenomenon to be observed and evaluated in terms of improving the energy efficiency of Italian hospitals is 1,062 principals, with a uniform distribution throughout the country. In the next paragraph, we present the methodology used to improve the energy efficiency of Italian hospitals.

3. METHODOLOGY

The methodological approach has been that of a joint evaluation both of organizational type that is energetic. The energy analysis concerned: The breakdown of electricity consumption, analysis of the consumption of the last 6 years derived from the monthly bills of hospitals, the consumption now, distribution of electricity consumption, and air conditioning needs. In the period between the years 2016 and 2022 using the data source of the Ministry of Health calculated for 1009 of the hospital principals estimated the total of 1062 annual average energy consumption, Using the same source, the average annual energy supply costs of Italian hospitals were calculated. The critical parameters for the Italian hospital principals were compared with those of the hospital principals of the 27 European Member States. The analysis of the energy bills of the 1062 hospitals, in particular, the absorption and equivalent hours show divergent results. The hourly consumption curves provide data that have been ordered and analyzed with MATLAB software to represent significant carpet plots for an energy balance. This analysis was carried out over 6 years, but the three graphs for the year 2022 are shown. The bottom-up and mouse-down approach to changing energy consumption to climate change has used data from the 20 Regional Environmental Protection Agencies (ARPA) as a source. The organizational analysis concerned: The plant characteristics of the structure, the age of the building and building maintenance over the last 6 years.

The 1,062 hospital garrisons (Istat, 2022) are divided into the national territory as follows: 216 in the northwest, 170 northeast, 231 centers, 280 South, and 165 Islands. Of the total of the principals who were contacted, only 5% were not available at the meeting for the proposed organizational and energy analysis. Therefore, 1009 hospital principals and their documentation were evaluated for the years considered: 2016-2022 both in terms of organizational and energy analysis. The 53 missings are divided among the 5 macro areas as follows, northwest 12, northeast 8, center 10, south 13 and islands 10. The Principals' Organisational and Energy Managers met the working group between February and December 2022 (Marino et al., 2022a). The collected data were processed for organizational analysis with the Enterprise Resource Planning method (ERP-Infor visual-Dynamic enterprise performance management/2022). Process mapping is a valuable tool for organizational analysis and the process of reviewing the organizational system (Marino et al., 2021; Marino et al., 2022b). The mapped processes were not only physical but also informative. This analysis tool allows the identification of the activities of each person and-possibly also through a timely survey for a significant

period-the relative time load to translate it into the saturation of the resource.

The investigation makes to emerge anomalies and criticalities in the allocation of the activities between functions and it is precisely on this that often is based a review of internal procedures to arrive at a king-design of portions of the organization: Such as merging into a single dedicated person, a series of activities previously distributed over multiple uncoordinated resources. The energy analysis and data processing were carried out with the Energy Software for Simplified Audits (SEAS) of National agency, new technologies, energy and sustainable development, (ENEA). The joint analysis, organizational and energy, represent one of the crucial moments in the implementation of a sustainable management system, both because it requires the hospital management an effort of analysis and overall evaluation of the site, both because its results depend on a large part of the choices regarding the organizational structure and characteristics of the energy management system within the hospital. The relationship between the two analyses, organizational and energy, allows us to better evaluate the results presented in the next paragraph.

4. RESULTS

In the period between 2016 and 2022, the average total primary energy consumption for Italian health facilities is 129.5 ktep divided into 62.7 ktep of electricity and 66.8 ktep of thermal energy, as highlighted in Table 1.

Table 2 shows the increasing costs of energy supply-average values-of Italian hospitals.

A comparison between energy consumption and associated costs shows a more marked gap in recent years; this trend is also justified by the recent pandemic and war events involving sources of energy supply. By evaluating the parameters among the various hospitals in the territory, it is possible to verify the widespread difficulty of the Italian Health System in the management of energy supply and distribution sources within the hospital facilities. Specifically, the following parameters are compared and then summarized in Table 3:

- Energy consumption in gross surface area [$\text{€}/\text{ep}/\text{m}^2$]
- Thermal energy compared to square meters and Degrees Day [$\text{€}/\text{Wh}/\text{m}^2 \text{DD}$]
- Electricity per square meter [$\text{€}/\text{Wh}/\text{m}^2$]
- Unit expenditure on electricity supply [$\text{€}/\text{€}/\text{Wh}$]
- Unit expenditure on methane supply [$\text{€}/\text{€}/\text{m}^3$]
- Unit expenditure on the supply of heat from district heating [$\text{€}/\text{€}/\text{Wh}$]

The elaboration of the results of the organizational analysis shows that the 1009 hospital principals had a structure in 1962 and the original body was built between 1959 and 1961. The extensions relate to:

- The building surface to be used for the shelter
- The surface of the laboratory activities and
- The management of the facilities.

In the 70 s 65% of the buildings were enlarged with other pavilions and in the early 90 s, other pavilions were built in 70%

Table 1: Source Ministero Della Salute-ns elaboration: Average annual consumption of Italian hospital principals

Year	Electricity [Tep]	Thermal energy [Tep]	TOT [Tep]	% E.E.	% T.E.
2016	49.650	56.339	105.989	47	53
2017	54.019	54.295	108.314	50	50
2018	58.032	57.939	115.971	50	50
2019	55.126	56.606	111.732	49	51
2020	54.045	50.676	104.721	52	48
2021	57.536	55.120	112.656	51	49
2022	56.802	57.154	113.956	50	50
Average	55.030	55.447	110.477	50	50

Table 2: Source Ministero della Salute-ns elaboration: Annual average costs energetic supply of the Italian hospitals

Year	Electricity [€]	Thermal Energy [€]	TOT [€]
2016	€ 30.617.263,00	€ 38.863.569,00	€ 69.480.832,00
2017	€ 34.110.712,00	€ 40.525.319,00	€ 74.636.031,00
2018	€ 47.327.137,00	€ 50.402.969,00	€ 97.730.106,00
2019	€ 48.044.675,00	€ 49.420.011,00	€ 97.464.686,00
2020	€ 46.786.558,00	€ 39.684.148,00	€ 86.470.706,00
2021	€ 45.489.397,00	€ 35.121.162,00	€ 80.610.559,00
2022	€ 42.297.572,00	€ 33.676.449,00	€ 75.974.021,00
Average	€ 42.096.187,71	€ 41.099.089,57	€ 83.195.277,29

Table 3: Source Ministero della Salute-Eurostat, ns elaboration (2016-2022)

Italian Hospital Principals comparison with the 27 European Countries			
Energy consumption in gross surface area	0.035	Tep/m ²	Low energy class
Thermal energy compared to square meters and degrees day	0.06	kWh/m ² DD	Low energy class
Electricity per square meter	125	kWh/m ² DD	Average energy class
Unit expenditure on electricity supply	0.39	€/kWh	Above average europe (0.16)
Unit expenditure on methane supply	0.44	€/Sm ³	Under average europe (0.43)
Unit expenditure on the supply of heat from district heating	92	€/MWh	Above average europe (70)

of the buildings studied. In the case of 320 garrisons, there are enlargement interventions that belong to both the 1970 s and 1990 s. The management of the plants to the location, expansion and installation of new plants, the various thermal plants, refrigeration units and substations of district heating, is varied within the structure, depending also on the different use of the departments over the years. In this field, plant engineering, it emerges from the ERP analysis that in the decision-making process there is an overlap of functions for the same decision of 7.5%, other data, in 65% of cases, the absence of structure dedicated to energy management, even if the figure of the energy manager is present in all the hospital principals. The age of buildings, in 87% of cases exceeds 60 years and maintenance over the last 6 years is around 16%. The energy analysis concerned: The characteristics of the electrical system, in particular, defined the distribution of electricity consumption within the buildings, dividing the energy absorbed by the various types of users. With this method, it will be easy to compare with

other average values available in the literature, with the possibility of finding criticalities in the system. In Table 4 we report the comparison between consumption and expenditure in the 6 years considered by the 1009 hospitals analyzed.

Starting from Table 1 it can be seen that consumption remains similar, even if compared with expenditure in the six reference years, there is a significant additional cost, as show in Table 4, therefore it is possible to suppose a monthly consumption calculated as average in this period but, considering in particular, the analysis of bills, Through the analysis of the distributor measurements and then concludes with the analysis of absorption and equivalent hours shows that energy expenditure in hospitals has increased significantly. After examining the bills of the last 6 years, to improve the comparison and analysis, electricity suppliers were asked for the hourly curves of consumption. The obtained data were ordered and analyzed with MATLAB software to represent significant carpet plots for an energy balance. This analysis was carried out over 6 years, but only three graphs are reported for the year 2022. It was done by varying the color bar of the graphs obtained, respectively on full-scale, minimum values (between 0 kWh and 650 kWh) and maximum values (between 650kWh and the maximum value found, 1165.5 kWh). Figure 1 shows the total scale hourly consumption values, Figure 2 shows the scale per hour consumption on the minimum scale and Figure 3 shows the scale on the maxima.

From the graphic representation you can make some considerations:

- The maximum value of energy measured is 1165.5 kWh measured at 15:00 on August 4, while lowering the scale to a minimum, the energy value never falls below 360 kWh
- The highest consumptions are measured in conjunction with the periods when there is air conditioning, in the hottest hours of the day
- In the night range between 23:00 and 6:00 consumption is much lower, and during the day you can see how, from 16:00/17:00 onwards consumption tends to decrease
- The difference between public and working days is clear, almost halving. This shows that electricity consumption is particularly dependent on work activities such as offices and clinics
- Almost abnormal behavior is evident in the first half of January.

The cooling requirement has been calculated in two different ways: Top-down and bottom-up. Top-down, we studied the trend of electricity consumption compared to the average external temperature; as can be seen from Figure 4, the consumption remains almost constant for temperatures below 14-15, while, for higher temperatures, the trend is increasing. This increase is

certainly attributable to the conditioning load, which increases with the increase in the external temperature.

It therefore also calculated the standard electricity requirement as the average value of consumption recorded for temperatures <15 °C and subtracted this proportion to days when the temperature is higher as in Figure 5.

Table 4: Comparison of consumption of E.E. in Euro during the analyzed time Source ns elaboration

Comparison of consumption and expenditure electricity MT from 2016 to 2022			
Year	Average 2016-2022		
	Avg temperature °C	TOT kWh	Cost [€] (no VAT)
2016	4.5	343903.3	46.161.18 €
2017	6.3	312920	42.333.92 €
2018	11.0	343927	46.349.20 €
2019	14.6	349818.7	47.196.57 €
2020	18.1	401758	54.546.98 €
2021	22.8	482275	63.960.49 €
2022	26.3	567570.5	76.385.41 €
Total cost			376.933.75 €

By carrying out this operation for 6 years the average need for conditioning was obtained at 14.1%.

Bottom-up. From the data of the refrigeration units and of the facilities' split systems, consumption was calculated on an annual basis assuming methods and hours of operation. As in talks with the hospital's technical staff, it was found that the refrigeration units were on average from mid-April to mid-October, in conjunction with the shutdown of the heating systems (except for particular climatic conditions). The assumption used for the calculation is an average of 12 per day of operation for all days of the period (180 days), except for groups currently undergoing restructuring, not yet operational. The power absorbed is assumed to be 30%, estimated from the characteristic absorption curve of the groups, initial absorption, followed by an exponential decrease. The annual consumption is calculated as:

$$\sum_{n=1}^{GF} Pot_{el,n} * 30\% * h_{fuz} \left[\frac{kWh}{year} \right]$$

Results are shown in Table 5.

Figure 1: Total scale hourly consumption values

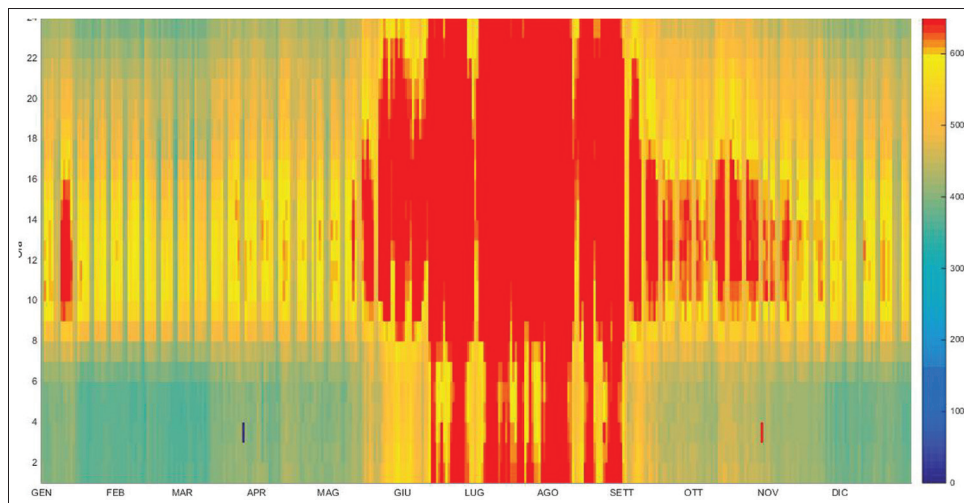


Figure 2: Scale per hour consumption on the minimum scale

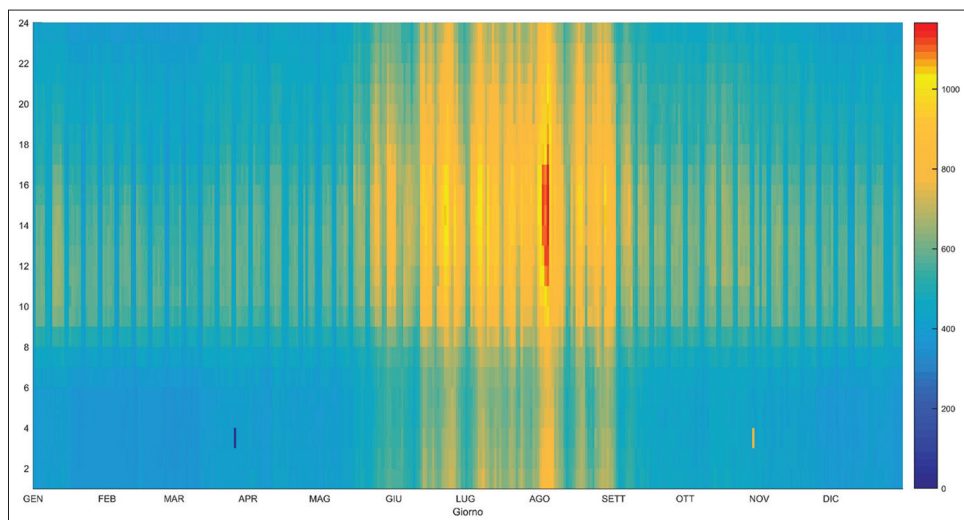


Figure 3: Scale on the maxima

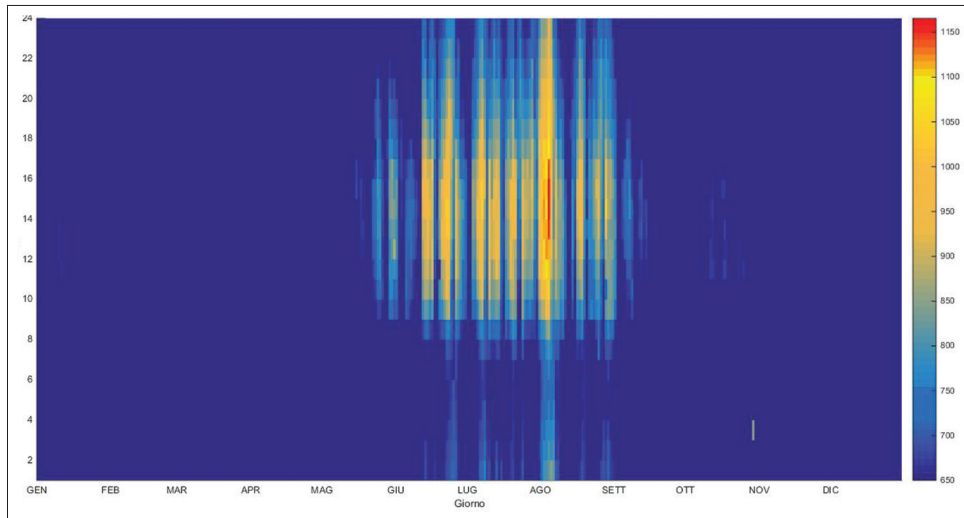


Figure 4: Average temperature versus the electric daily consumption

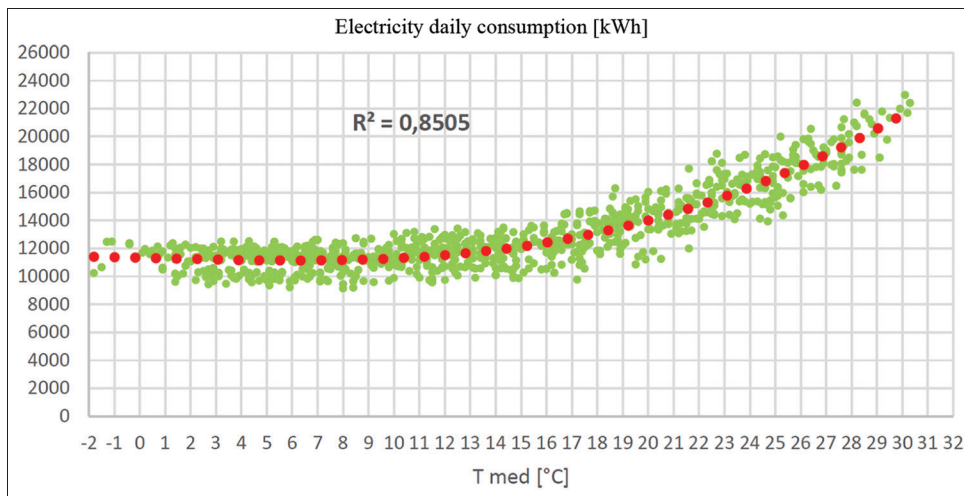
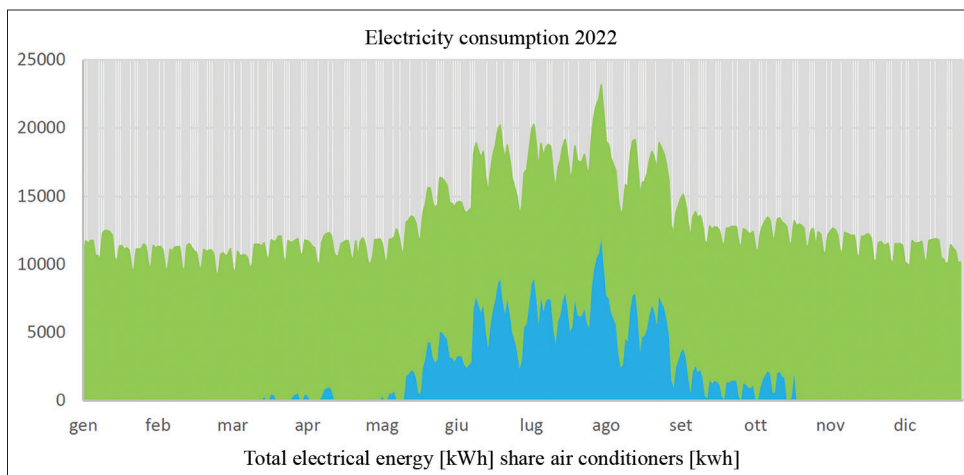


Figure 5: Consumption subdivision with conditioning quota



In the same way, obtained the calculation of the split systems present in hospital facilities, the average electricity consumption was calculated, assuming 8 h of operation for portable systems and 6 h per day of operation for all the others, for only 122 days

of the summer period; the power absorbed was calculated by multiplying by the electrical absorption efficiency $\eta = 97\%$ the electrical power shown on the data sheets of the different models. Annual consumption is shown in Table 6.

The joint analysis of the 1009 Italian hospitals, highlights, the criticality and potential that are reported in the following paragraph.

5. DISCUSSION

The processes of organizational and energy management such as health, increasingly have to deal with the stringent requirements of sustainability dictated by the recent economic

Table 5: Annual consumption calculated for the refrigeration units of hospitals

Installed electrical power [kW]	Electrical power absorbed [kW]	h equivalent	Consumption [kWh/Year]
66.18	19.85	2160	42882.4
66.18	19.85	2160	42882.4
66.18	19.85	2160	42882.4
62.70	18.81	2160	40629.6
112.50	33.75	2160	72900
86.51	25.95	2160	56058.48
86.51	25.95	2160	56058.48
88.10	26.43	2160	57088.8
19.70	5.91	2160	12765.6
62.70	18.81	2160	40629.6
62.70	18.81	2160	40629.6
62.70	18.81	2160	40629.6
19.70	5.91	2160	12765.6
18.10	5.43	2160	11728.8
270.00	81.00	0	0
270.00	81.00	0	0
Annual total			570531.2

crisis and subsequent European directives. These require energy redevelopment by combining the high-quality parameters required by citizens and the need for the National Health System to comply with budgetary constraints. The results show that the energy efficiency of Italian hospitals the European average, has structural weaknesses, but energy efficiency for Italian hospitals is also a strategic lever to restart. Healthcare construction is extremely involved in these objectives since it is one of the most energy-intensive sectors because of the many functions it incorporates and the need to operate the services provided, which must be guaranteed, at least for hospital facilities, 24 h a day 365 days a year, ensuring:

- a. Continuity in medical services
- b. High thermal comfort (in winter and summer) for patients and staff
- c. Healthy working and hospitalization environments.

In Italy, from the research carried out, it emerges that the patrimony of hospital principals, in most cases, is no longer suitable for current uses, The buildings were built in times when regulatory constraints were not stringent and there was no attention to the issues of efficiency and energy saving. The hospital structures should be adaptable to the continuous evolution of the technologies and the organization of the Services and instead are structures that over the years fall into obsolescence. Over the years there have been no technological innovations to cope with the continuous and increasing use of facilities and adaptation to new regulations. This absence is evident in all its difficulties of implementation when, and this is the Italian case, the incidence of costs for energy consumption is predominant in an economic situation dictated by

Table 6: Annual consumption calculated for split plants

Numbers of installation split	Tot. installed power [kW]	Power adsorbed [kW]	h equivalent	Consumption [kWh/Year]
4	3.5	3.395	732	2485.1
1	2	1.94	732	1420.1
11	12	11.64	732	8520.5
10	12.1	11.737	732	8591.5
10	12	11.64	732	8520.5
7	7.1	6.887	732	5041.3
1	1.5	1.455	732	1065.1
1	0.9	0.873	732	639
5	4	3.88	732	2840.2
4	4.15	4.0255	732	2946.7
1	0.9	0.873	732	639
20	18	17.46	732	12780.7
3	2.9	2.813	732	2059.1
1	0.75	0.7275	732	532.5
1	0.9	0.873	732	639
5	5	4.85	732	3550.2
2	1.8	1.746	732	1278.1
8	7.8	7.566	732	5538.3
5	5.7	5.529	732	4047.2
1	0.75	0.7275	732	532.5
3	3.8	3.686	732	2698.2
1	1.3	1.261	732	923.1
1	1.5	1.455	732	1065.1
1	0.9	0.873	732	639
2	1.8	1.746	732	1278.1
1	0.9	0.873	732	639
30	30	29.1	976	28401.6
Total for the Year				109310.7

the crisis of supply of energy sources and relative increase in costs. In addition, no work has been undertaken over time to modernize the old hospital complexes, it is unlikely that these changes will lead to an optimization of energy consumption, but they may lead to partial improvements that do not significantly affect overall consumption. About a third of the energy consumed in Italy is related to the health sector. In this sector, hospital principals have average consumption three times higher than in the residential civil sector in similar climatic conditions (ENEA, 2022). These buildings, therefore, have ample energy and economic savings that can be achieved both through more prudent management of energy flows and through energy efficiency interventions of the building-plant systems. In the total budget of the National Health System, the energy, thermal and electricity supply correspond respectively to 5% and 2.2% of the budget share, equal to 27% of total expenditure (ENEA, 2022), a significant figure for our country. Attacking this figure, saving a share with the rationalization of consumption has the consequence of freeing economic resources for the entire public sector.

Net of a new building for hospital principals, some actions are possible in the short term. A first action for the reduction of the expense regards the reorganization of the relative management to the energetic efficiency, eliminating the decisional and operating duplication present in the management process is the possible saving of 7%. A second action is to structure energy efficiency units and establish the role of the energy manager. The high potential for energy saving and therefore economics that can be achieved in the field of Health, cannot ignore a key figure, the energy manager as head of the structure dedicated to energy management. Structure and professional figures can represent in hospital facilities an opportunity for rational use of energy resources of a certain structure, based on data collected by monitoring systems, on the empirical observation of installations and the continuous analysis of energy performance indicators. This figure and structure are necessary to determine the energy performance of each hospital with skills related to the identification and characterization of cost centers and the correct definition of energy efficiency interventions. Third short-term action, the mandate of this structure must make priority technological investments both to implement the reduction of energy consumption of hospital facilities and for interventions aimed at reducing dispersion and implementation of technologies for the exploitation of renewable energy sources. These three actions can improve the energy efficiency of Italian hospitals. The current energy and economic crisis, requires hospitals the need to support the priority of the health service, therefore clinical-diagnostic, and energy. It's a necessary cultural and organizational change to be achieved quickly. The European Directives from 2012/27/UE, concerning the energy efficiency of energy end-uses and energy services, to reduce emissions and respect the European targets set, has given a strong impetus to the energy upgrading of buildings to achieve minimum energy efficiency standards, Encouraging Member States to support the public sector in the examination of energy service offers by using and managing particular Service Contracts. Italy as emerges from the research presents a strong weakness concerning the energy efficiency of hospital facilities used to provide health services.

6. CONCLUSIONS AND POLICY IMPLICATIONS

The energy management of hospital facilities is complex due to the large amounts of energy used and transformed the performance of all health and non-health activities that take place daily in the 1062 hospitals analyzed. The hospital is the only public building that does not know breaks in its daily activities throughout the year. It is a structure in operation 24 h and 365 days a year. The different services provided have a multiplicity of energy consumption profiles and can be essentially divided into two main categories: hotel-type consumption for the well-being of patients and staff and consumption more closely related to health functions supported by treatment and diagnosis equipment.

In recent years, numerous opportunities for energy upgrading of buildings have not been implemented by creating energy profiles of obsolete and inefficient hospital facilities. Moreover, the obtained financings have regarded interventions centered on the core business of the hospital garrisons, therefore, investments in medical technologies for the diagnosis and the treatment of the pathologies, or more urgent building interventions such as regulatory adaptation in terms of safety of structures. A possible way to obtain financial resources that allow important interventions of requalification and energy efficiency of health facilities, requires a management change, both energy and organizational.

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